CONNECTICUT QUITLINE
1-800-QUIT-NOW

FAX Referral Form

Fax Number: 1-800-483-3114

Provider Information: **Fax Sent Date:** _____/_____/_____

Clinic Name: _____

Health Care Provider: _____

I am a HIPAA-Covered Entity (Please check one) ___ **Yes** __ **No** __ **I Don't Know**

Contact Name: _____

Fax: (_____) _____ - _____ **Phone** (_____) _____ - _____

Comments:

Patient Information:

Patient Name: _____ **DOB:** _____/_____/_____

Address: _____ **City:** _____ **Zip:** _____

Gender: ☐**Male /** ☐**Female** **Pregnant?** ☐**Y /** ☐**N**

Primary #: (_____) _____ - _____ **Type:** ☐**HM** ☐**WK** ☐**CELL** ☐**OTHER**

Secondary #: (_____) _____ - _____ **Type:** ☐**HM** ☐**WK** ☐**CELL** ☐**OTHER**

Language Preference (check one): ☐**English** ☐**Spanish** ☐**Other -** _____

Tobacco Type (check ALL that apply): ☐**Cigarettes** ☐**Smokeless Tobacco** ☐**Cigar** ☐**Pipe**

_____ I am ready to quit tobacco and request the Connecticut QuitLine contact me to help me with my quit plan.
(Initial)

_____ I **DO NOT** give my permission to the Connecticut QuitLine to leave a message when contacting me.
(Initial)

Patient Signature: _____ **Date:** _____/_____/_____

The Connecticut QuitLine will call you. Please check the BEST 3-hour time frame for them to reach you. NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.

❑ **6am - 9am** ❑ **9am - 12pm** ❑ **12pm - 3pm** ❑ **3pm - 6pm** ❑ **6pm - 9pm**

Within this 3-hour time frame, please contact me at (check one): ☐**Primary Phone # /** ☐**Secondary Phone**

Connecticut Department of Public Health – Tobacco Use Prevention and Control Program